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HOUSE BILL 2031 By
McDaniel

SENATE BILL 2078
By Atchley

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 32, relative to revising the statutory definition of health maintenance organizations; amending the licensing and regulatory requirements for health maintenance organizations to ensure the financial viability of such organizations and that such organizations provide quality health care to the citizens of this state; providing coordinated oversight of health maintenance organizations by the Tennessee Department of Commerce and Insurance and the Tennessee Department of Health; prohibiting unauthorized entities from assuming risk so as to ensure the financial well-being of Tennessee's health care delivery system; lowering the premium tax liability for certain health maintenance organizations; and providing the Tennessee Department of Commerce and Insurance adequate remedies to pursue collection of premium tax liabilities of health maintenance organizations.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-32-202, is amended by deleting current subsection (1) and by substituting instead the following:

"Basic health care services" means those health care services which the commissioner determines an enrollee might reasonably require in order to be maintained in good health including at a minimum, but not limited to, emergency care, inpatient hospital and physician care, ambulatory physician care, outpatient preventive medical services, and diagnostic laboratory services and diagnostic and therapeutic radiological services. "Basic health care services" also means preventive health care services, including but not limited to periodic physical examinations, prenatal obstetrical care and "well-child" care.

SECTION 2. Tennessee Code Annotated, Section 56-32-202, is amended by deleting the ";" at the end of current Section (6) and by substituting instead the following:

The definition of health maintenance organization shall also include, effective December 31, 1996 all entities receiving state or federal funds directly from the State of Tennessee to extend medical assistance to persons who are medically needy pursuant to any federal waiver received by the State of Tennessee that waives any or all of the provisions of title XIX of the federal Social Security Act, and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan.

SECTION 3. Tennessee Code Annotated, Section 56-32-202, is amended by deleting current subsection (9) and by substituting instead the following:

"Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency.

SECTION 4. Tennessee Code Annotated, Section 56-32-202 is amended by deleting the "and" at the end of current Section 56-32-202(9), adding the following items and renumbering all definitions in this section in alphabetical order:

(1) "Affiliate" means any person which exercises control over or is controlled by the health maintenance organization, and the term "control" shall have the same meaning as set forth at § 56-11-201(a)(3);

(2) "Assuming risk" means incurring actuarial risk of loss which includes but is not limited to the receipt of capitation payments from a health maintenance organization to provide health care services, or a portion thereof, where the recipient pays a subcontractor for some or all of the same services on other than a capitated basis. No risk is assumed when a recipient of capitation payments from a health maintenance

organization pays a subcontractor on a sub-capitated basis to provide the services, or a portion thereof, that the recipient is obligated to provide the enrollees of the health maintenance organization;

(4) “Capitation payment” means the method of payment for health services in which a person is paid a fixed amount for each enrollee served, without regard to the actual number or nature of services provided to each person in a set period of time;

(6) “Co-payment” is the fixed monetary amount an enrollee is required to pay a provider when specific services are rendered;

(11) “Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt approved by the commissioner;

(14) “Premium” means the gross amount of all dollars collected by the health maintenance organization from an enrollee or on an enrollee’s behalf;

(15) “Primary care provider” is a provider who takes responsibility for the overall coordination of the care of an enrollee’s health problems be they biological, behavioral, or social;

(17) “Supplemental health care services” means any health care services other than basic health care services that a health maintenance organization may cover, but is not required to cover, and includes but is not limited to dental care, vision care and optometric services, including lenses and frames;

(18) “Surplus” means assets less liabilities and capital;

(20) “Working capital” means current assets minus current liabilities.

SECTION 5. Tennessee Code Annotated, Section 56-32-203 (b), is amended by adding the following item and re-numbering accordingly:

(8) Full and complete disclosure of any financial interest held by an officer or a director of the applicant in any provider that has an ownership interest in the applicant or any provider under contract to provide services to enrollees of the applicant;

SECTION 6. Tennessee Code Annotated, Section 56-32-203(b), is amended by deleting current item (11) and substituting the following:

(11) A statement to be utilized by the commissioner of health which generally describes the following:

(A) The applicant's health care plan or plans;

(B) The location of facilities where health care shall be available to enrollees, the types of health care personnel to be used at each location, the approximate number of each personnel type available at each location, and the business hours of each facility;

(C) The method used to monitor the quality of health care services furnished;

(D) The applicant's definition of a medical emergency and the procedures for enrollees to follow in the case of a medical emergency;

(E) The ability to develop, compile, evaluate, and report statistics relating to the pattern of utilization and the availability and accessibility of the applicant's services provided by either the applicant or its designees; and

(F) A description of the complaint procedure to be used by enrollees and providers, including but limited to the procedure to accept complaints and to answer questions from enrollees and providers over the telephone;

SECTION 7. Tennessee Code Annotated, Section 56-32-203(e), is amended by deleting the section in its entirety and by substituting instead the following:

(e) An applicant must demonstrate to the commissioner of health proof of capability to provide basic health care services efficiently, effectively and economically. The commissioner of health shall report his or her findings to the commissioner of commerce and insurance, who may then deny the application for a certificate of authority, as provided in §§ 56-32-204 and 56-32-218(b).

SECTION 8. Tennessee Code Annotated, Section 56-32-204(a)(3)(F), is amended by deleting this section in its entirety and by substituting instead the following:

(F) Whether the health maintenance organization has met the standards for financial viability set forth in § 56-32-212.

SECTION 9. Tennessee Code Annotated, Section 56-32-207(a)(3)(B), is amended by adding the following items:

(v) At a minimum, a listing of all the health maintenance organization's primary care providers and their respective addresses and phone numbers or, if a primary care provider has been assigned, a notification of the official assignment of the enrollee to a particular primary care provider and his address and telephone number. Each health maintenance organization shall annually provide each enrollee a provider directory listing the organization's primary care providers, with their respective addresses and telephone numbers.

(vi) Information on how to obtain referrals, prior authorization, or a second opinion and information containing the health maintenance organization's definition of a medical emergency, specific examples of what constitutes an emergency, and what procedures an enrollee should follow in order for an emergency to be covered under the health maintenance organization's plan. The health maintenance organization shall also include information on the appropriate use, location, and hours of operation of any urgent care facilities operated by the health maintenance organization and on any potential responsibility of enrollees for payment for non-emergency services rendered to the enrollee in a hospital emergency facility.

SECTION 10. Tennessee Code Annotated, Section 56-32-207(a)(3), is amended by adding the following new subsection (D):

(D) An identification card issued to each enrollee which shall specify at a minimum the name, address, and telephone number of the health maintenance

organization, the full name, birth date, and social security number of the enrollee, and the telephone number to call for instruction on how to receive authorization for emergency care.

SECTION 11. Tennessee Code Annotated, Section 56-32-208, is amended by deleting this section in its entirety and adding the following language:

(a) Every health maintenance organization shall annually, on or before March 1, file with the commissioner a report on the blank prescribed by the National Association of Insurance Commissioners for health maintenance organizations.

(b) Every health maintenance organization shall also file with the commissioner a quarterly financial report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations. These reports shall be filed on or before March 1 (covering last quarter of previous year), June 1 (covering first quarter of current year), September 1 (covering second quarter of current year) and December 1 (covering third quarter of current year) of each calendar year. These quarterly statements shall include a form stating the total amount of uncovered and covered expenses that are payable and are more than ninety (90) days past due, with a general description of each such expense.

(c) The annual and quarterly statements referenced in subsections (a) and (b) shall also be filed on a computer diskette using a format acceptable to the commissioner.

(d) Any health maintenance organization that neglects to make and file its statements in the form and within the time provided by subsections (a) and (b) shall forfeit two hundred dollars ($200.00) for each day neglected and, upon notice by the commissioner to that effect, its authority to do new business shall cease until all such defaults are cured. Any health maintenance organization that fails to correct or revise any statement filed under subsections (a) and (b) within thirty (30) days after written

request by the commissioner shall forfeit two hundred dollars ($200.00) for each day neglected and, upon notice by the commissioner, its authority to do new business shall cease until all statements are properly corrected and revised.

(e) For willfully making a false annual or other statement, a health maintenance organization, and persons making oath to or subscribing to the same, shall be severally punished by civil penalty of not less than one thousand dollars ($1,000.00) and not more than twenty thousand dollars ($20,000.00). The assessment of such civil penalty shall not preclude the commissioner from pursuing any other remedy at law for a health maintenance organization or person willfully making a false annual or other statement. Within fifteen (15) days after the assessment of any civil penalty under this section, the person assessed may request a hearing on the legitimacy of the civil penalty. Such hearings shall be conducted pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(f) The commissioner may require such additional reports as are deemed reasonably necessary and appropriate to enable the commissioner to carry out the commissioner's duties under this part.

SECTION 12. Tennessee Code Annotated, Section 56-32-209, is amended by deleting this section in its entirety and replacing this section with the following language:

(a) An enrollee must be notified in writing by the health maintenance organization of termination of the primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

(b) Health maintenance organizations shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized

standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility and continuity of care.

(c) Health maintenance organizations shall have an ongoing internal quality assurance program to monitor and evaluate their health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and non-institutional settings. The program shall include, at a minimum, the following:

(1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) A written quality assurance plan which describes the following:

(A) The health maintenance organization's scope and purpose in quality assurance;

(B) The organizational structure responsible for quality assurance activities;

(C) Contractual arrangements, where appropriate, for delegation of quality assurance activities;

(D) Confidentiality policies and procedures;

(E) A system of ongoing evaluation activities;

(F) A system of focused evaluation activities;

(G) A system for credentialing providers and performing peer review activities; and

(H) Duties and responsibilities of the designated physician responsible for the quality assurance activities;

(3) A written statement describing the system of ongoing quality assurance activities including:

(A) Problem assessment, identification, selection and study;

(B) Corrective action, monitoring, evaluation and reassessment; and

(C) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

(5) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

(d) Health maintenance organizations shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available for review by the commissioner of health.

(e) Health maintenance organizations shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(f) Enrollee clinical records shall be available to the commissioner of health or an authorized designee for examination and review to ascertain compliance with this section. Such records shall be maintained as confidential by the commissioner of health, to the extent required by law.

(g) Health maintenance organizations shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

SECTION 13. Tennessee Code Annotated, Section 56-32-210, is amended by adding new subsection (c) as follows, and renumbering accordingly:

(c) Every health maintenance organization shall maintain records of written complaints filed with it. Copies of complaints and responses shall be available for inspection by the commissioner of commerce and insurance, the commissioner of health, and examiners of either commissioner for a period of three (3) years.

SECTION 14. Tennessee Code Annotated, Section 56-32-212, is amended by deleting this section in its entirety and replacing this section with the following language:

(a) To satisfy the public's interest in the delivery of health care services by fiscally sound health maintenance organizations, each such organization must provide the commissioner evidence of compliance with the following minimum net worth requirements:

(1) Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of two million dollars ($2,000,000), and thereafter health maintenance organizations must maintain the minimum net worth as set forth herein.

(2) Except as provided in paragraphs (3) and (4) of this subsection, every health maintenance organization must maintain a minimum net worth equal to the greater of:

(A) Two million dollars ($2,000,000); or

(B) An amount totaling three percent (3%) of the first $150,000,000 of annual premium revenue as reported on the most recent annual statement filed with the commissioner and one and one-half

percent (1.5%) of the annual premium revenue in excess of $150,000,000; or

(C) An amount equal to the sum of three months uncovered expenditures as reported on the most recent financial statement filed with the commissioner.

(3) A health maintenance organization licensed before July 1, 1996 must maintain a minimum net worth of:

(A) Fifty percent (50%) of the amount required by § 56-32-212(a)(2) by December 31, 1996;

(B) Seventy-five percent (75%) of the amount required by § 56-32-212(a)(2) by July 1, 1997;

(C) One hundred percent (100%) of the amount required by § 56-32-212(a)(2) by December 31, 1997.

(4) In determining net worth, no debt shall be considered fully subordinated unless in a form approved by the commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated. The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses.

(5) For purposes of calculating a health maintenance organization's net worth the term "admitted assets" includes the following, as may be subsequently modified by the commissioner by rule or regulation:

(A) Petty cash and other cash funds in the organization's principal or official branch office that are under the organization's control;

(B) Immediately withdrawable funds on deposit in demand accounts, in a bank or trust company organized and regularly examined under the laws of the United States or any state, and insured by an

agency of the United States government, or like funds actually in the principal or official branch office at statement date, and, in transit to a bank or trust company with authentic deposit credit given before the close of business on the fifth bank working day following the statement date;

(C) The amount fairly estimated as recoverable on cash deposited in a closed bank or trust company, if the assets qualified under this section before the suspension of the bank or trust company;

(D) Receivables due from persons that are not more than ninety (90) days past due;

(E) Amounts due under reinsurance arrangements from insurance companies authorized to do business in this state;

(F) Undisputed tax refunds from the United States or this state;

(G) Amounts on deposit under § 56-32-212(b); and

(H) Investments determined as allowable by the commissioner under § 56-32-211.

(6) A health maintenance organization must maintain a positive working capital.

(7) If the working capital or net worth is less than the required minimum, the operations of the health maintenance organization must be adjusted to correct the net worth or working capital according to a written plan proposed by the organization and approved by the commissioner within thirty (30) days after the commissioner has notified the health maintenance organization that its net worth or working capital requirements are deficient. The commissioner may take action against the health maintenance organization under § 56-32-216 or § 56-32-217 if:

(A) A health maintenance organization does not propose a plan to correct its working capital or net worth within the time frame described above;

(B) A health maintenance organization violates a plan that has been approved;

(C) The commissioner determines that an improper working capital or net worth status cannot be corrected within a reasonable time; or

(D) The commissioner determines that an organization is in such financial condition that the transaction of further business would be hazardous to its enrollees, its creditors, or the public.

(b) To ensure that a health maintenance organization provides for contract and medical services in the case of insolvency or liquidation, each health maintenance organization must maintain deposits in custodial or controlled accounts as described herein.

(1) Before issuing any certificate of authority, the commissioner shall require each health maintenance organization to deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a value of not less than seven hundred thousand dollars ($700,000).

(2) A health maintenance organization that is in operation on July 1, 1996, shall maintain a deposit equal to seven hundred thousand dollars ($700,000), in the manner set forth in subsection (1) above. Each such organization shall

provide evidence of such deposit to the commissioner within ninety (90) days after July 1, 1996.

(3) In addition to the above deposit requirements, a health maintenance organization shall also maintain on deposit in the manner set forth in subsection (1) above one hundred thousand dollars ($100,000) for each ten million dollars ($10,000,000) or fraction thereof of annual premium revenue in excess of twenty million dollars ($20,000,000) as reported on the most recent annual financial statement filed with the commissioner. Any health maintenance organization that is in operation on July 1, 1996, shall provide evidence of such deposit to the commissioner within one hundred fifty (150) days after July 1, 1996.

(4) In any year in which the accumulated deposit of a health maintenance organization is more than the amount required to be maintained by such organization under the terms of this section, at the organization's request the commissioner shall reduce the previously accumulated deposit by the amount that the deposit exceeds the amount of deposit required by this section.

(5) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

(6) All income from deposits shall be an asset of the organization. A health maintenance organization that has been allowed by the commissioner to make a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value as approved by the commissioner. No substitute deposit shall be allowed unless approved in advance by the commissioner.

(7) The deposit shall be used and shall be considered held in trust to protect the interests of the health maintenance organization's enrollees and to

assure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or liquidation. If the health maintenance organization is placed voluntarily or involuntarily in rehabilitation or liquidation, the deposit shall immediately prior to the filing of the rehabilitation or liquidation proceeding vest in the State of Tennessee.

(c) Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims. Such liabilities may be computed in accordance with rules and regulations promulgated by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

(d) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

(e) An agreement to provide health care services between a provider and a health maintenance organization must require that if the provider terminates the

agreement, the provider shall give the organization at least sixty (60) days advance notice of termination.

SECTION 15. Tennessee Code Annotated, Section 56-32-215, is amended by deleting this section in its entirety and substituting the following language as a new section:

(a) The commissioner of commerce and insurance, in cooperation with the commissioner of health, shall coordinate the regulation of health maintenance organizations holding a certificate of authority so as to ensure the financial viability of such organizations and that such organizations are currently providing and shall in the future provide basic health care services and if applicable supplemental health care services efficiently, effectively and economically. The commissioner of commerce and insurance and the commissioner of health shall develop an inter-department agreement to coordinate the functions necessary for the proper administration of this section.

(b) The commissioner of commerce and insurance may make an examination of the affairs of any health maintenance organization and any providers with whom the health maintenance organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state. Such examinations of health maintenance organizations shall occur not less frequently than once every five (5) years. The commissioner of commerce and insurance may also contract, at reasonable fees for work performed, with qualified, impartial outside sources to perform audits or examinations or portions thereof pertaining to the qualification of an entity for issuance for a certificate of authority to operate as a health maintenance organization or to determine the continued compliance of any operating health maintenance organization. Any contracted assistance shall be under the direct supervision of the commissioner of commerce and insurance. The results of any contracted assistance shall be subject to the review of, and approval, disapproval, or modification by, the commissioner of commerce and insurance.

(c) The commissioner of health or the commissioner's designee may make an examination concerning the quality assurance program of any health maintenance organization and any providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state. Such examinations of health maintenance organizations shall occur not less frequently than once every three (3) years. The commissioner of health shall report findings to the commissioner of commerce and insurance, who may then suspend or revoke a certificate of authority issued to the health maintenance organization as provided in § 56-32-216.

(d) Every health maintenance organization and provider shall submit its books and records for such examinations and in every way facilitate the completion of the examination. For the purpose of examinations, the commissioner of commerce and insurance and the commissioner of health may administer oaths to, and examine officers and agents of, the health maintenance organizations, and providers as well as the principals of providers.

(e) The expenses of examinations of health maintenance organizations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner for whom the examination is being conducted.

(f) In lieu of such examinations, the commissioner of commerce and insurance or the commissioner of health may accept the report of an examination made by the commissioner of insurance or the commissioner of health of another state.

SECTION 16. Tennessee Code Annotated, Section 56-32-216(a)(5), is amended by deleting the punctuation ";" at the end of the item and by substituting instead the following:

, including but not limited to failing to maintain the minimum net worth and deposit requirements set forth at § 56-32-212, failing to comply with § 56-32-206(b) or § 56-32-208(d), or violating § 56-32-208(e),

SECTION 17. Tennessee Code Annotated, Section 56-32-218(a) is amended by adding the following language after the words “the commissioner”:

of commerce and insurance and the commissioner of health.

SECTION 18. Tennessee Code Annotated, Section 56-32-220, is amended by adding the following subsection:

(d) If the commissioner of health determines that there are not enough providers to assure that enrollees have accessible health services available in a geographic service area, the commissioner of commerce and insurance may, in lieu of suspension or revocation of a certificate of authority, institute a plan of corrective action that shall be followed by the health maintenance organization within thirty (30) days after the sending of the plan of corrective action. Such a plan may include but not be limited to requiring the health maintenance organization to make payments to non-participating providers for health services to enrollees, requiring the health maintenance organization to discontinue accepting new enrollees in that service area, and requiring the health maintenance organization to reduce its geographic service area. The commissioner of health may, by rule or regulation, establish standards to determine whether a health maintenance organization has sufficient providers in a geographic service to assure that enrollees have accessible health services.

SECTION 19. Tennessee Code Annotated, Section 56-32-221, is amended by adding the following subsection:

(d) Nothing in the Tennessee Insurance Code or this title shall be deemed to authorize any health maintenance organization to transact any insurance business other than that of a health maintenance organization pursuant to this chapter unless it is

authorized under certificate of authority issued by the commissioner of commerce and insurance under the provisions of the Tennessee Insurance Code.

SECTION 20. Tennessee Code Annotated, Section 56-32-224, is amended by deleting this section in its entirety and by substituting instead the following:

(a) All health maintenance organizations doing business in this state shall pay tax on the gross amount of all dollars collected from an enrollee or on an enrollee's behalf in the amount of two percent (2%). However, effective July 1, 1996, all health maintenance organizations which receive any payments directly from the State of Tennessee to provide any health care services to enrollees in a federal or state program designed to extend medical assistance to persons who are medically needy pursuant to either any federal waiver received by the State of Tennessee that waives any or all of the provisions of title XIX of the Social Security Act or any other federal law as adopted by amendment to the required title XIX state plan, shall only pay a tax of one and three quarters percent (1.75%) on such payments.

(b) Such taxes shall be paid on a quarterly basis with payments being due and payable on June 1 (for first quarter of calendar year), September 1 (for second quarter of calendar year), December 1 (for third quarter of calendar year) and March 1 (for fourth quarter of preceding calendar year). Any person failing or refusing to render tax statement information or to pay the taxes specified in this section shall be subject to § 56-4-216.

(c) The amount of taxes collected in this section shall be a single credit against the sum total of the taxes imposed by the Franchise Tax Law, compiled in title 67, chapter 4, part 9, and by the Excise Tax Law, compiled in title 67, chapter 4, part 8.

(d) The commissioner or designee shall be vested with the following powers to ensure the collection of this tax:

(1) To examine at the expense of the health maintenance organization the books and records of the organization for the purpose of determining the amount of taxes due, in the event of the failure of the organization to make its return, or for the purpose of verifying or correcting any return made;

(2) To issue assessments for the collection of any tax due and unpaid, or to institute suits in the courts of law or chancery to obtain collection of any tax due and unpaid, and for the purpose of this section the commissioner shall be considered a resident of all counties of this state; and

(3) To compromise and settle, with the approval of the attorney general and reporter, any tax dispute under this section which is not yet in litigation.

SECTION 21. Chapter 32 of Title 56 is amended by adding a new section, T.C.A. § 56-32-226, which shall read as follows:

No entity shall be authorized to assume risk as defined in this chapter unless that entity has obtained a certificate of authority under Title 56 or is otherwise authorized to assume risk by law. The attorney general and reporter, upon request and on behalf of the commissioner, may institute suits in the chancery courts to enjoin any entity from assuming risk in contravention of this section. If an entity is found to be acting in contravention of this section then such entity, and the directors and officers of such entity, shall be jointly and severally liable for any costs incurred by the attorney general and reporter in enforcing the provisions of this section, including attorney's fees, and shall also be subject to a civil penalty not less than ten thousand dollars ($10,000) nor more than two hundred thousand dollars ($200,000). For purposes of this section the commissioner shall be considered a resident of all counties of this state.

SECTION 22. This act shall take effect upon July 1, 1996, the public welfare requiring it.